MDR Tracking Number: M5-04-3711-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 6-28-04.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that hot-cold pack therapy, manual therapy technique, pelvic ultrasound, ultrasound-soft tissue of head/neck, ultrasound extremity non-vascular, short latency, therapeutic activities, therapeutic exercises, ROM measurement, muscle testing and level III office visits from 8-4-03 through 10-31-03 were not medically necessary.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity fees were the only fees involved in the medical dispute to be resolved. As the services listed above were not found to be medically necessary, reimbursement for dates of service 8-4-03 through 10-31-03 are denied and the Medical Review Division declines to issue an Order in this dispute.

This Decision is hereby issued this 27th day of September, 2004.

Donna Auby
Medical Dispute Resolution Officer
Medical Review Division

DA/da

August 27, 2004

Texas Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

Re: Medical Dispute Resolution
MDR #: M5-04-3711-01
TWCC#:
Injured Employee:
DOI:
SS#:
IRO Certificate No.: 5055

Dear

___ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of ___ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in Chiropractic Medicine and is currently on the TWCC Approved Doctor List.

REVIEWER'S REPORT

Information Provided for Review:
TWCC-60, Table of Disputed Services, EOB's
Information provided by Requestor: correspondence, office notes, daily progress notes, therapeutic procedures, electrodiagnostic test, procedure report and radiology reports.
Information provided by Respondent: correspondence.
Information provided by D.O.: office notes.
Information provided by Neurosurgeon: office notes.

Clinical History:
Patient is a 51-year-old female who suffered a work-related injury on ___. She had immediate pain in her neck, mid-back, lower back and right wrist and presented herself the next day to a doctor of chiropractic for conservative chiropractic care, including physical therapy and rehabilitation. Despite the conservative trial, she eventually underwent epidural steroid injections.

Disputed Services:
Hot/cold pack therapy, manual therapy technique, pelvic ultrasound, ultrasound-soft tissue of head/neck, ultrasound extremity non-vascular, short latency, therapeutic activities, therapeutic exercises, ROM measurement, muscle testing, and level III office visits during the period of 08/04/03 through 10/31/03.

Decision:
The reviewer agrees with the determination of the insurance carrier and is of the opinion that the treatment and services in dispute as stated above were not medically necessary in this case.

Rationale:
In this case, the medical records submitted failed to demonstrate that the prescribed

care was offering any material benefit. In fact, the daily treatment notes stated that the patient continued to report pain levels of 6-10/10 on each follow up visit with notations like “condition so far is getting worse” and “it hurts more severe and constantly” (08/27/03), and “Patient states that there is not much change in her condition and that she is in constant pain” (09/02/03).

The *Guidelines for Chiropractic Quality Assurance and Practice Parameters*[1] Chapter 8 under “Failure to Meet Treatment/Care Objectives” state, “After a maximum of two trial therapy series of manual procedures lasting up to two weeks each (four weeks total) without significant documented improvement, manual procedures may no longer be appropriate and alternative care should be considered.” Since the documentation submitted revealed that the care in this case failed to achieve the desired result, the medical necessity of all care past 08/23/03 is not supported due to the absence of documented functional improvement.

The medical necessity for a clinical trial of conservative care consisting of those treatments and modalities was supported for a 4-week trial, but not after 08/23/03 when the care was documented as ineffective.

[1] Haldeman, S; Chapman-Smith, D; Petersen, D *Guidelines for Chiropractic Quality Assurance and Practice Parameters,* Aspen Publishers, Inc. 1993